STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155383		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/16/2012	
	PROVIDER OR SUPPLIER		8201 W	ADDRESS, CITY, STATE, ZIP CODE WASHINGTON ST JAPOLIS, IN 46231	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDENCE N. AN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F0000	This visit was for State Licensure	or a Recertification and e Survey.	F0000		
	Survey dates: March 12, 13, 14, 15, & 16, 2012				
	Facility Numbe Provider Numb AIM Number:	er: 155383			
	Survey team: Patti Allen BSV Marcy Smith R Leia Alley RN Dinah Smith RI	N			
	Census bed typ SNF/NF: 81 Total: 81	oe:			
	Census payor for Medicare: 15 Medicaid: 53 Other: 13 Total: 81	type:			
		cies also reflect state n accordance with 410			
	Quality review Williams, RN	3/23/12 by Suzanne			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED		
		155383	B. WING		03/16/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIEF	8		WASHINGTON ST	
WASHING	GTON HEALTH CA	ARE CENTER	INDIANAPOLIS, IN 46231		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0156 SS=D	483.10(b)(5) - (1) NOTICE OF RIG CHARGES The facility must orally and in writ resident underst all rules and reg conduct and resident with the developed under Such notification upon admission stay. Receipt of amendments to writing. The facility must entitled to Medication when the resident Medicaid of the inicluded in nursing State plan and for be charged; those that the facility oresident may be charges for those resident when chard services spead (B) of this services and during the resident available in the formus the facility's per services not covered the services of the facility's per services of the facility's per services not covered the facility's per services.	O), 483.10(b)(1) CHTS, RULES, SERVICES, Inform the resident both ing in a language that the ands of his or her rights and ulations governing resident ponsibilities during the stay in facility must also provide the enotice (if any) of the State of \$1919(e)(6) of the Act. In must be made prior to or and during the resident's such information, and any it, must be acknowledged in inform each resident who is raid benefits, in writing, at the into the nursing facility or, in the comes eligible for items and services that are ing facility services under the or which the resident may not see other items and services ffers and for which the charged, and the amount of e services; and inform each manges are made to the items recified in paragraphs (5)(i)(A) rection. Inform each resident before, admission, and periodically ent's stay, of services for including any charges for ered under Medicare or by diem rate.	TAG	DEPLIENCY)	DATE
,			1		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IKCV11

Facility ID: 000393

If continuation sheet

Page 2 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP	LE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00	COMPL	
		155383	B. WING			03/16/	2012
NAME OF P	DOMDED OF GUIDNI 155		STR	EET A	DDRESS, CITY, STATE, ZIP CODE	•	
NAME OF P	ROVIDER OR SUPPLIER		820)1 W	WASHINGTON ST		
	GTON HEALTH CA)IAN	APOLIS, IN 46231		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION		
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAC	j	DEFICIENCY)		DATE
		the manner of protecting under paragraph (c) of this					
		the requirements and					
		stablishing eligibility for					
		ing the right to request an					
		er section 1924(c) which extent of a couple's					
		ources at the time of					
	•	n and attributes to the					
		se an equitable share of					
	resources which	cannot be considered					
		ment toward the cost of the					
		spouse's medical care in his					
		f spending down to Medicaid					
	eligibility levels.						
		nes, addresses, and					
	•	ers of all pertinent State					
		groups such as the State rication agency, the State					
	-	the State ombudsman					
	· ·	tection and advocacy					
		Medicaid fraud control unit;					
		that the resident may file a					
	•	ne State survey and					
		ncy concerning resident					
		and misappropriation of					
		in the facility, and					
	non-compliance requirements.	with the advance directives					
	requirements.						
	The facility must	comply with the					
		ecified in subpart I of part					
		er related to maintaining					
		ind procedures regarding					
		es. These requirements					
	•	ns to inform and provide					
		on to all adult residents					
		ight to accept or refuse					
	medical or surgic	cal treatment and, at the		l			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IKCV11

Facility ID: 000393

If continuation sheet Page 3 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155383	B. WIN			03/16/	2012
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF P	ROVIDER OR SUPPLIER			8201 W	WASHINGTON ST		
	GTON HEALTH CA				APOLIS, IN 46231		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		TE	COMPLETION DATE	
TAG		on, formulate an advance	+	TAG			DATE
		ncludes a written description					
	of the facility's policies to implement advance directives and applicable State law.						
	Th - f:::4	::					
	The facility must inform each resident of the name, specialty, and way of contacting the						
		nsible for his or her care.					
	, , , , , , , , , , , , , , , , , , , ,						
	-	prominently display in the					
	,	formation, and provide to					
		oplicants for admission oral mation about how to apply for					
		re and Medicaid benefits, and					
		efunds for previous payments					
	covered by such	benefits.					
	A) Based on re	ecord review and	F01	56	What corrective action(s) will be		04/12/2012
		acility failed to ensure			accomplished for those Reside found to have been affected by		
	a resident's far	mily/responsible party			the deficient practice? Reside	•	
	was provided v	vith information			Council meeting on 4/4/2012 t		
	regarding cost	of services not covered			place showing Residents whe	re	
	by Medicaid or	Medicare at time of			to locate Residents Rights		
	admission and	what their financial			posting with discussion of examples of Residents' Rights		
	liability was du	ring Medicaid Pending			Resident Council discussed or		
	process. This				4/4/12 what an Ombudsman is		
		se families were			where to locate Ombudsman		
	interviewed. (F	Resident# 111)			phone number in facility as we as where to locate Ombudsma		
					brochures. Residents currently		
	,	terview, the facility			waiting for Medicaid approval,		
		e residents were aware			received information on month	ıly	
	•	or 2 of 2 resident			statement sent on 4/4/12		
	council membe				regarding liability. Executive Director inserviced Director of		
		knowledge of resident			Admissions 0n 4/4/12 on facili		
	rights. (Reside	nts #26 and #40)			Resident Rights policy for	,	
					Resident/Responsible party to		
	Findings Includ	le:			receive copy of Resident Righ		
					location of names, addresses, and telephone numbers of all		
					and relebilione unitibels of all		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IKCV11

Facility ID: 000393

If continuation sheet Page 4 of 26

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155383	B. WING			03/16/	2012
NAME OF P	DOMINED OF CHIRD IEL			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF			8201 W	WASHINGTON ST		
	GTON HEALTH CA				APOLIS, IN 46231	-	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
	`				CROSS-REFERENCED TO THE APPROPRIAT	TE	
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	pertinent state client advocacy groups, incuding the State Ombudsman program, and documents of covered service under Medicaid and Medicare upon admission. Social Service Director and Activities Director participated on 4/4/12 in show Residents where to locate Resident Rights posting with examples of Residents' Rights and Ombudsman information. How will you identify other Residents having the potential be affected by the same defici practice? All Residents have potential to be affected by this alleged deficient practice. Resident Council meeting on 4/4/2012 showing Residents Rig posting with discussion of examples of Residents' Rights where to locate Residents Rig posting with discussion of examples of Residents' Rights Resident Council discussed of 4/4/12 what an Ombudsman is where to locate Ombudsman phone number in facility as we as where to locate Ombudsman phone number in facility as we as where to locate Ombudsman phone number in facility on 4/4 to meet with Residents. What measures will you put in place what systematic changes you make to ensure that the deficient practice does not recur? Executive Director inserviced Director of Admissions on faci policy for Resident/Responsib	s, eer ring I to ent the hts I to s, ell an y ent e or will ent lity	COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IKCV11

Facility ID: 000393

If continuation sheet Page 5 of 26

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155383		A. BUILDING	00	COMPLETED 03/16/2012			
	PROVIDER OR SUPPLIE	R	B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				party to receive copy of Reside Rights, location of names, addresses, and telephone numbers of all pertinent state client advocacy groups, incuding the State Ombudsmaprogram, and documents of covered services under Medicand Medicare, upon admission Admission paperwork for thos Residents admitted after 4/4/r includes acknowledgement of following: receipt of Resident Rights, Ombudsman informat list of covered items under Medicaid and Medicare, and explanation of liability. Social Service Director and Activities Director participated in showin Residents where to locate Resident Rights posting with examples of Residents' Rights and Ombudsman information. Residents and/or Responsible Party to receive updated Residents Rights information, Ombudsman information, list covered items under Medicaid and Medicare, with explanation liability by 4/12/12 via hand delivery or standard mail. Ombudsman will be preat facility on 4/9/12 to meet will Residents. All Residents to receive Ombudsman brochure 4/12/12. All new employees to receive Residents Rights orientation upon hire, and at least once annually. How the corrective action(s) will be monitored to ensure the deficient of the pread	an caid n. se 12 f the s ion, s an S All e of d on of sent ith e by east		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IKCV11

Facility ID: 000393

If continuation sheet

Page 6 of 26

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2012 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/16/2012
	ROVIDER OR SUPPLIE	R	8201 W	ADDRESS, CITY, STATE, ZIP CODE / WASHINGTON ST IAPOLIS, IN 46231	1
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION DATE
	A) During an in	terview on 3/13/12 at		quality assurance program of put into place? Executive Director will provide increase monitoring for Resident Right Resident Rights policy was developed for Resident/Responsible party receive copy of Resident Rights policy receive copy of Resident Rights policy receive copy of Resident Rights policy receive copy of Resident Rights and telephone numbers of a pertinent state client advoca groups, incuding the State Ombudsman program, and documents of covered servicunder Medicaid and Medicaid upon admission. Resident Raudit tool will be utilized weed 4 weeks, monthly x 6, then quarterly thereafter to ensurance are aware of Resident Rights, Residents Rights proat admission, Ombudsman information accessible to all Residents in facility and macavailable upon admission. Resident Rights audit tool wutilized weekly x 4 weeks, monthly x 6, then quarterly thereafter to ensure Resident and/or Responsible Parties I acknowledged receipt of list covered items under Medica and Medicare, and information grading liability. If thresho of 95% is not achieved an achieved an achieved an achieved an achieved and will be developed, one-on-one re-education and disciplinary action may occur noncompliance.	to ghts, es, II cy ces re, tights ekly x e ole nts ovided de ill be nts has of aid on old ction d/or
	10:10 a.m., Res	sident #111's family			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IKCV11

Facility ID: 000393

If continuation sheet

Page 7 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155383	B. WING	G		03/16/	2012
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
					WASHINGTON ST		
WASHIN	IGTON HEALTH CA	ARE CENTER		INDIAN	APOLIS, IN 46231		
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	†	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		cility did not inform them					
		would incur over the time					
	_	esident #111 would be					
		proved for state funded					
	assistance, and t	hat they were issued a bill					
	for around \$160	0.00. The family of					
	Resident # 111 i	indicated they had not					
	received any inf	formation about resident					
	liability nor did	the family receive a					
	facility list of ite	ems and charges not					
	covered by Med	icaid and/or Medicare.					
	During an interv	view with the ED					
	(Executive Dire	ctor) and Admissions					
	`	14/11 at 2:40 p.m., they					
		hen family members are					
		Resident #111's are, they					
	· ·	cost of services over the					
	phone in a telep	hone conference call.					
	-	tion was requested in					
		formation given to the					
	_	telephone conference, at					
	this time of inter	•					
	During an interv	view with the Admissions					
	_	14/12 at 3:15 p.m., she					
	indicated they d	• '					
	_	egard to cost and charges					
		conference with Resident					
	#111's family.	comprehence with resident					
	TITIS failing.						
	During an inters	view with the ED on					
		p.m., further information					
		bout the bill the family					
1	I was requested at	bout the only the faililly	ı				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IKCV11

Facility ID: 000393

If continuation sheet Page 8 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155383	B. WIN			03/16/2012	
NAME OF I	PROVIDER OR SUPPLIER	•	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	-	
NAME OF F	NO VIDER OR SUFFLIER				WASHINGTON ST		
	GTON HEALTH CA				APOLIS, IN 46231		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	1
TAG		,		IAG	BEHOLIKETY	DATE	—
	received from the	•					
	-	nterview with the					
	•	o handles resident funds					
	_	usiness Office Manager					
		ilable during the time of					
	_	ated there was a check					
		d from a family member					
		amount of \$830.00. The					
	Receptionist was	not able to explain					
	exactly what the	payment was for.					
	On 3-16-12 at 4:	30 p.m., during interview					
	with the ED (Exe	ecutive Director), she					
	indicated there w	vas no documentation the					
	family had been	informed of the liability					
	1	ility service list of					
		red by Medicaid and/or					
	Medicare.	iou of intoliousu usius of					
	Tyredicare.						
	B) During an ir	nterview with Resident					
	Council Preside	ent on 3/14/12 at 10:30					
	a.m., Resident	#26, she indicated she					
	thought resider						
	-	ouncil meetings but she					
		give an example of a					
		She indicated she did					
	not know the re						
		ey were available and					
	she did not kno	•					
	Ombudsman w						
	2 maaaman w						
	During an inter	view with the Resident					
		resident on 3/15/12 at					
		ident #40, he indicated					
	3.43 a.III., RESI 	ident #40, ne mulcated					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IKCV11

Facility ID: 000393

If continuation sheet

Page 9 of 26

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155383	A. BUILDING	00	03/16/2012
		.50000	B. WING	ADDRESS CITY STATE ZIP CODE	00/10/2012
NAME OF P	PROVIDER OR SUPPLIER	R		ADDRESS, CITY, STATE, ZIP CODE WASHINGTON ST	
	GTON HEALTH CA			APOLIS, IN 46231	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	1	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
TAG		of resident rights but he	IAG		DATE
		give an example. He			
		d not know the results			
		ection survey were			
	available in the	front lobby. He also			
		d not know what an			
	Ombudsman w	as or how to call him.			
	3 1 4(2)				
	3.1-4(a)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IKCV11

Facility ID: 000393

If continuation sheet Page 10 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING			
		155383	B. WING		03/16/2012
	PROVIDER OR SUPPLIE		8201 V	ADDRESS, CITY, STATE, ZIP CODE V WASHINGTON ST NAPOLIS, IN 46231	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0160 SS=A	UPON DEATH Upon the death fund deposited of must convey wit funds, and a finat to the individual administering th Based on reco interview, the f within 30 days upon death, to administering f 1 of 1 resident funds disburse (Resident #54) Findings Include During an inter 2:00 p.m., with handles reside regarding a de funds/account review. The facility pro Resident #54's what was done however, they of the check th the state for re Medicaid funds	the resident's funds the individual the resident's estate for reviewed for personal ment upon death. de: view on 3/14/12 at the Receptionist who ents' funds, information ceased resident's was requested for vided documentation of account balance and e with the amount; did not provide a copy at was issued back to imbursement of	F0160	What corrective action(s) will accomplished for those Residif found to have been affected by the deficient practice? Facility issued check on 3/16/12 back the State of Indiana for reimbursement. How will you identify other Residents having the potential to be affected by same deficient practice? All Residents have the potential to be affected by same deficient practice. On 4/6/12, Business Office Manager reviewed all Resident Trust Fundaccounts, concluding all accordurent for Residents decease last 30 days. What measures you put in place or what systematic changes you will not one sure that the deficient practice does not recur? Business Office Manager will review all Resident Trust Fundaccounts monthly to ensure conveyance of personal funds upon death within 30 days to the individual or probate jurisdiction administering the Resident's estate. On 4/6/12, Business Office Manager reviewed all Resident Trust Fundaccounts Trust Fundaccounts accounts Fundaccounts accounts a	ents y t to g the o und unts d in will nake

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IKCV11

Facility ID: 000393

If continuation sheet

Page 11 of 26

	TOF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/16/2012
	PROVIDER OR SUPPLIER		STREET 8201 V	ADDRESS, CITY, STATE, ZIP CODE V WASHINGTON ST NAPOLIS, IN 46231	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	9:20 a.m., furth requested about issued back to resident's fundational department of the state o	view with front desk n 3/16/12 at 11:00 ated Resident #54's ued today, 3/16/12, te of Indiana for n. Resident #54 had		for Residents deceased in last days. How the corrective action(s) will be monitored to ensure the deficient practice who trecur, i.e. what quality assurance program will be pure into place? Business Office Manager or designee will utilize Conveyance of Personal Fundaudit tool monthly to ensure conveyance of personal funds upon death. If 100% threshold not achieved an action plan whose developed, one-on-one re-education and/or disciplinate action may occur for noncompliance.	vill t ze ds d is

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IKCV11

Facility ID: 000393

If continuation sheet

Page 12 of 26

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155383	B. WIN			03/16/	2012
			p. ,, 12,		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				WASHINGTON ST		
WASHIN	GTON HEALTH CA	RE CENTER			APOLIS, IN 46231		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0167 SS=C	483.10(g)(1) RIGHT TO SUR' ACCESSIBLE A resident has the results of the monofacility conducted surveyors and an with respect to the surveyors and an with respect to the surveyors and an with respect to the facility must for examination and readily accessible a notice of their and Based on obsetthe facility failed the availability was posted and most recent staffacility's plan of displayed in a resident surveyor.	make the results available and must post in a place e to residents and must post	F01	67	What corrective action(s) will be accomplished for those Reside found to have been affected by the deficient practice? New posting of state survey results availability and labeled binder containing state survey results was completed by 3/26/12. Resident Council meeting on 4/4/12 involved discussion with	ents y	04/12/2012
	visitors for 2 of representatives the potential to and their visitor #40) Findings includ During a tour of at 3:35 p.m., a observed sitting front desk in the was not labeled plan of correction binder. Informatical informatical plan of correction binder.	2 resident council s interviewed. This had affect all 81 residents rs. (Residents #26 and			4/4/12 involved discussion with the Residents by Social Service Director and Executive Director on where recent survey results availability is posted and where most recent survey results with plan of correction are kept. St assisted Residents to show eathe survey results availability posting and labeled binder indicating State survey results with plan of correction. Resided Council President satisfied with explanation and availability of survey results and plans of correction. How will you identified the potential to be affected by the same deficient practice? All Residents have the potential to	ce or s e aff ach ent h	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IKCV11

Facility ID: 000393

If continuation sheet Page 13 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155383	B. WING		03/16/2012
		l .		ADDRESS, CITY, STATE, ZIP CODE	l
NAME OF P	PROVIDER OR SUPPLIER			/ WASHINGTON ST	
VVV CITIVI	GTON HEALTH CA	DE CENTED		IAPOLIS, IN 46231	
WASIIIN	GTONTIEALTITUA	INE CENTER	INDIAN	IAF OLIS, IN 40231	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	found during th	is tour.		be affected by this alleged	
				deficient practice. New postin	· .
	During an inter	view with Resident		state survey results availability	/
		ent on 3/14/12 at 10:30		and labeled binder containing	
				state survey results was	. [
		#26, she indicated she		completed by 3/26/12. Reside	ent
		e results of a state		Council meeting on 4/4/12	
	inspection surv	ey were available or		involved discussion with the Residents by Social Service	
	where to look for	or them.		Director and Executive Director	nr
				on where recent survey result	
	During an inter	view with the Resident		availability is posted and wher	
		resident on 3/15/12 at		most recent survey results wit	
				plan of correction are kept. St	
	· ·	ident #40, he indicated		assisted Residents to show ea	
		v the results of a state		the survey results availability	
		ey were available in		posting and labeled binder	
	the front lobby.			indicating State survey results	
				with plan of correction. What	
	3.1-3(b)(1)			measures will you put in place	
				what systematic changes you	
				make to ensure that the defici	
				practice does not recur? New posting of state survey results	
				availability and labeled binder	
				containing state survey results	
				was completed by 3/26/12. S	
				survey results audit tool by	
				Quality Assurance Committee	will
				be utilized weekly x 4 weeks,	
				monthly x 6, then quarterly	
				thereafter to ensure posting of	
				availability and labeled binder	
				include state survey results ar	nd
				plans of correction. How the	
				corrective action(s) will be	
				monitored to ensure the defici	
				practice will not recur, i.e. what quality assurance program will	
				put into place? State survey	I DC
				results audit tool by Quality	
				Assurance Committee will be	
				. Issued Sommittee will be	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155383	A. BUILDING		03/16/2012
			B. WING STREET	ADDRESS, CITY, STATE, ZIP CODE	ı
NAME OF P	PROVIDER OR SUPPLIER	t		/ WASHINGTON ST	
WASHIN	GTON HEALTH CA	RE CENTER	INDIAN	IAPOLIS, IN 46231	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	utilized weekly x 4 weeks,	DATE
				monthly x 6, then quarterly	
				thereafter to ensure posting of	
				availability and labeled binde include state survey results a	
				plans of correction.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IKCV11

Facility ID: 000393

If continuation sheet

Page 15 of 26

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	PLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	LDING	00	COMPL	ETED
		155383	B. WIN			03/16/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
VAVA CLUINI		DE CENTED			WASHINGTON ST		
WASHING	GTON HEALTH CA	RE CENTER		INDIAN	APOLIS, IN 46231		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	· L	DATE
F0441	483.65						
SS=E	INFECTION CO	NTROL, PREVENT					
	SPREAD, LINEN						
		establish and maintain an					
	•	Program designed to					
		anitary and comfortable					
	environment and	to help prevent the					
	development and	d transmission of disease					
	and infection.						
	(a) Infection Con	trol Program					
	The facility must	establish an Infection					
	Control Program						
	(1) Investigates,	controls, and prevents					
	infections in the	facility;					
	(2) Decides wha	t procedures, such as					
	isolation, should	be applied to an individual					
	resident; and						
	` '	ecord of incidents and					
	corrective action	s related to infections.					
		pread of Infection					
	` '	ection Control Program					
		a resident needs isolation to					
		ad of infection, the facility					
	must isolate the						
	· ,	ust prohibit employees with a					
		isease or infected skin					
		ct contact with residents or					
		ct contact will transmit the					
	disease.	and an arrive staff to the first terms of the staff to th					
		ust require staff to wash their					
		direct resident contact for					
		ning is indicated by accepted					
	professional prac	Stice.					
	(c) Linens						
		handle, store, process and					
		so as to prevent the spread					
	of infection.	to to provent and oprodu					
		nyation intonvious and	F04	4 1	What corrective action(s) will b	ie.	04/12/2012
		rvation, interview and	1.04	7.1	accomplished for those Reside		UT/12/2012
	record review,	the facility failed to			accomplished for those reside	1110	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IKCV11

Facility ID: 000393

If continuation sheet

Page 16 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155383	1			03/16/	/2012
			B. WIN		ADDRESS CITY STATE TIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
14/4 01 115	07011151171101	DE CENTED			/ WASHINGTON ST		
WASHIN	GTON HEALTH CA	ARE CENTER		INDIAN	IAPOLIS, IN 46231		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
	ensure precaut	tions were followed to			found to have been affected b	у	
	prevent the pot	tential spread of			the deficient practice?		
	infection for 1 of	of 2 residents observed			One-on-one inservicing by	oto d	
	for isolation pre	ecautions. This had			Infection Control nurse conduby 4/6/12 for those staff that n		
	-	affect 20 residents			need further education related		
	-	300 hall. (Resident #			infection control program and		
	_	Joo Hall. (IXESIGEIIL#			preventing the spread of		
	67)				infection. All staff, including		
	 				nursing and laundry staff, to		
	Findings includ	led:			complete inservice training an	d	
					skills validation by 4/12/12 on		
	On 3/15/12 at 9:35 a.m., an isolation				Infection Control precautions		
	supply contained	er was observed			including, but not limited to,		
		ent #67's room. There			isolation rooms with posting a		
		the door to caution			door cautioning staff or visitor before entering room, proper		
	_	before entering the			of gloves when removing item		
		before entering the			from isolation room, proper		
	room.				transport and placement of so	iled	
					linens from isolation room,		
		ng Assistant (CNA) #1			handwashing, and proper use	of	
	was observed	in Resident #67's room			personal protective equipmen	t to	
	at this time with	nout gloves on,			ensure the prevention of the		
	removing the re	esident's breakfast			potential spread of infection.		
	tray.				Contracted lab to provide		
					inservice training to lab		
	Certified Nursin	ng Assistant (CNA) #2			technicians regarding facility's infection control program by	•	
		at 9:40 a.m. on this			4/12/12. New soiled linen bar	rels	
					for linens from isolation rooms		
		clear plastic bag of			designated in three soiled utili		
		room. He indicated he			rooms. How will you identify o	-	
	was taking it to	the soiled utility room.			Residents having the potentia		
	He placed the	bag on the counter of			be affected by the same defic	ient	
	the soiled utility	y room. He indicated			practice? All Residents have		
		supposed to place			potential to be affected by this	;	
	isolation linens or clothing in the				alleged deficient practice.		
	regular soiled container. He indicated				One-on-one inservicing by	oto d	
					Infection Control nurse condu		
	1	ff would know it was			by 4/6/12 for those staff that n need further education related		
	i trom an isolatio	on room because it was			I heed intrier education related	ı iU	1

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155383				03/16/	2012
			B. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
MA CLIIN	CTON HEALTH CA	ADE CENTED			WASHINGTON ST		
WASHIN	GTON HEALTH CA	ARE CENTER		INDIAN	APOLIS, IN 46231		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	set aside.				infection control program and		
	During an inter	view at 9:49 a.m. on			preventing the spread of		
	this date, 3/15/	12, with RN #3, she			infection. All staff, including nursing and laundry staff, to		
	indicated bagg	ed linen from an			complete inservice training an	Ч	
		should be taken to the			skills validation by 4/12/12 on	u	
		om and placed in the			Infection Control precautions		
	_	but at 10:56 a.m. RN			including, but not limited to,		
	· · · · · · · · · · · · · · · · · · ·				isolation rooms with posting a		
		e bags containing			door cautioning staff or visitor		
	soiled linen and	_			before entering room, proper i		
		s should be taken			of gloves when removing item	S	
	directly to the laundry by staff, not				from isolation room, proper	9-1	
	placed in the s	oiled utility room.			transport and placement of so linens from isolation room,	ilea	
					handwashing, and proper use	of	
	At 9:40 a.m., a	contracted lab			personal protective equipmen		
		observed coming out			ensure the prevention of the	0	
		7's room. She was			potential spread of infection.		
		oving her gown and			Contracted lab to provide		
					inservice training to lab		
		cing them in a plastic			technicians regarding facility's	;	
	_	ving the room. She did			infection control program by		
		ands after she took off			4/12/12. New soiled linen bar for linens from isolation rooms		
	her gloves. At				designated in three soiled utili		
	contracted lab	technician again exited			rooms. What measures will yo		
	from Resident	#67's room after			put in place or what systemati		
	removing her g	loves and gown and			changes you will make to ens		
	placing them in	n a plastic bag. She			that the deficient practice does	S	
	I	vash her hands before			not recur? All staff, including		
	exiting the roor				nursing and laundry staff, to		
	Calling the roof				complete inservice training an	d	
	During an inter	view with the			skills validation by 4/12/12 on Infection Control precautions		
	During an inter				including, but not limited to,		
		on 3/16/12 at 9:00 a.m.,			isolation rooms with posting a	t	
		soiled linen and clothing			door cautioning staff or visitors		
	from isolation rooms should be placed				before entering room, proper		
	in the regular soiled container in the				of gloves when removing item		
	utility room alo	ng with the other soiled			from isolation room, proper		
	linen and cloth	ing. She indicated			transport and placement of so	iled	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	ETED
		155383				03/16/	2012
			B. WIN				_
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
					WASHINGTON ST		
WASHIN	GTON HEALTH CA	ARE CENTER		INDIAN	APOLIS, IN 46231		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	everything is w	ashed together			linens from isolation room,		
	because the ch	nemicals will disinfect			handwashing, and proper use		
	everything.				personal protective equipment	to	
					ensure the prevention of the		
	During on into	riani niith tha			potential spread of infection.		
	During an inter				Infection Control nurse and	_	
		Supervisor on 3/16/12			Laundry Supervisor will provid increased monitoring for	C	
	·	she indicated the staff			appropriate transportation of		
	is supposed to	bag isolation linen and			linens, handwashing, and prop	er	
	clothing separa	ately and set it aside,			use of personal		
	and laundry staff then knows it is from				protective equipment. Infection	า	
	1	om and treats it			control nurse or designee will		
	differently.	on and treate it			complete infection control aud	it	
	dilierently.				tool 5x weekly for 4 weeks and	t	
					monthly thereafter to ensure s		
	· ·	licy titled "Pathogen			are providing safe, sanitary an		
	Reduction for 0	On-Premise Laundry,"			comfortable environment and		
	received from t	the Administrator on			help prevent the development		
	3/13/12 at 2:20	p.m., indicated			and transmission of disease a	nd	
		ning contaminated			infection through facility's		
	_	e clearly identified with			infection control program. Ho the corrective action(s) will be	W	
	1	•			monitored to ensure the deficie	ant	
		oding, or other methods			practice will not recur, i.e. wha		
		care workers handle			quality assurance program will		
	these items sa	fely"			put into place? Infection contr		
					nurse or designee will complet		
	During an inter	view with Licensed			infection control audit tool 5x		
	Practical Nurse	e (LPN) #5 on 3/16/12			weekly for 4 weeks and month	ıly	
	at 6:10 p.m., he				thereafter to ensure staff are		
		currently residing on			providing safe, sanitary and		
		nere CNAs #1 and #2			comfortable environment and		
		iele Olyas #1 allu #2			help prevent the development		
	were working.				and transmission of disease a	nd	
					infection through facility's	50/2	
	On 3/12/12, 4:4	44 p.m. Laundry Aide			infection control program. If 9	J /0	
	#4 was observed wearing a yellow						
		9				or	
	1	-					
	1	_			noncompliance.		
	#4 was observed isolation gown the front lobby.	· ·			threshold is not achieved an action plan will be developed, one-on-one re-education and/disciplinary action may occur f	or	

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155383	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/16/2012
	PROVIDER OR SUPPLIER IGTON HEALTH CARE CENTER	8201 W	ADDRESS, CITY, STATE, ZIP CODE WASHINGTON ST APOLIS, IN 46231	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	she wore it while she worked in the laundry room with the residents' soiled linen and clothing. She indicated she keeps the gown on when she leaves the laundry room and goes out into the facility where the residents live. During an interview with the Housekeeping Supervisor on 3/16/12 at 10:00 a.m., she indicated the laundry aides were supposed to wear gowns and gloves at all times when working with soiled linen and clothing. She indicated if the laundry aides leave the laundry area, they should remove their gowns and gloves. Review of an Infection Control Policy received from the DoN (Director of Nursing) on 3/15/12 at 4:00 p.m., indicated "Hand HygienePerform hand hygiene:after contact with blood, body fluids or excretions, mucous membranes, non-intact skin or wound dressing, After contact with intact skinAfter removing glovesGloves Wear gloves when it can be anticipated that contact with blood or other potentially infectious materialsproviding direct resident care, cleaning environment or equipmentGownPerform hand hygiene before leaving roomTransmission-Based Precautions:Post a 'Please, See			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IKCV11

Facility ID: 000393

If continuation sheet

Page 20 of 26

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155383	A. BUILDING B. WING	00	COMPI 03/16	LETED
	PROVIDER OR SUPPLIE		8201 W	ADDRESS, CITY, STATE, ZIP CO / WASHINGTON ST IAPOLIS, IN 46231	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	REGULATORY OF			CROSS-REPERENCED IOTHE AIDEPICIENCY)	PPROPRIATE	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IKCV11

Facility ID: 000393

If continuation sheet

Page 21 of 26

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	PLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING	00	COMPL	ETED
		155383	B. WING	1110		03/16/	2012
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				WASHINGTON ST		
WASHIN	GTON HEALTH CA	RE CENTER			APOLIS, IN 46231		
					W 0201		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	1	TAG	DEFICIENCY)		DATE
F0520	483.75(o)(1)						
SS=F		EE-MEMBERS/MEET					
	QUARTERLY/PL	LANS					
	Λ facility must m	aintain a quality assessment					
	_	ommittee consisting of the					
		ig services; a physician					
		e facility; and at least 3 other					
	members of the						
		ssment and assurance					
		s at least quarterly to identify					
	issues with respect to which quality						
		assurance activities are					
	_	develops and implements sof action to correct					
	identified quality						
	identified quality	deliciences.					
	A State or the S	ecretary may not require					
		records of such committee					
	except insofar as	s such disclosure is related to					
	-	of such committee with the					
	requirements of	this section.					
	Cood faith attain	mto but the comment to a to					
		pts by the committee to ect quality deficiencies will					
		basis for sanctions.					
			F0520	,	What corrective action(s) will b	. Δ	04/12/2012
		view and observation,	10520	´	accomplished for those Reside		O T/ 12/2012
	-	d to effectively address			found to have been affected by		
		erns regarding infection			the deficient practice? Quality		
		nt liability and providing			Assurance Committee held		
	a list of items/s	ervices not covered by			meeting on 3/27/12 to address		
	Medicare/Medic	caid, informing			areas of infection control, resid	lent	
	residents of the	eir rights, including the			liability and providing list of		
		tate survey results.			items/services not covered by		
	•	otential to affect 81 of			Medicare/Medicaid, informing Residents of their rights, include	lina	
	•	siding in the facility.			the availability of state survey	iiig	
	OT TOSIGOTIES IC	oranig in the facility.			results. Quality Assurance		
	Eindings instit	0.			Committee developed audit to	ols	
	Findings includ	ᠸ.			by 4/3/12 to utilize at least		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IKCV11

Facility ID: 000393

If continuation sheet Page 22 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDING	00	COMPLETED	
		155383	B. WIN	NG		03/16/2012	
NAME OF B			•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	C		8201 W	WASHINGTON ST		
	GTON HEALTH CA	RE CENTER			APOLIS, IN 46231		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	·	X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	LETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG		DA	TE
TAG	On 3-16-12 at a interview with the Director), she in The Quality As had not address the ED indicate ensure the result with the facility was displayed easily accessibility visitors. The Quality As had not address information about the facility served to the facility served t	4:30 p.m., during he ED (Executive ndicated the following: surance Committee sed resident rights. ed the facility failed to alts of the most recent ted by State Surveyors is plan of correction in a manner which was alle to residents and surance Committee sed providing any out resident liability nor tee discuss providing ice charge list of items Medicaid and/or surance Committee sed the infection in The ED indicated in prevention tools in		TAG	quarterly to identify issues with respect to quality assessment and assurance of infection control, resident liability and providing list of item/services is covered by Medicare/Medicaid informing Residents of their rigincluding the availability of stasurvey results. Medical Direct to approve plan by 4/6/12. Howill you identify other Residen having the potential to be affected by the same deficient practice. All Residents have the potential be affected by this alleged deficient practice. Items in grievance logs utlized by Residents, families, visitors, astaff will be reviewed by Quality Assurance Committee. Quality Assurance Committee held meeting on 3/27/12 to address areas of infection control, residiability and providing list of items/services not covered by Medicare/Medicaid, informing Residents of their rights, incluit the availability of state survey results. Quality Assurance Committee developed audit to by 4/3/12 to utilize at least quarterly to identify issues with respect to quality assessment and assurance of infection control, resident liability and providing list of item/services is covered by Medicare/Medicaid informing Residents of their rigincluding the availability of state survey results. Medical Direct survey results. Medical Direct survey results. Medical Direct	not I, I) Inot II, I) III III III III III III III III	TE
						or nat	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155383	A. BUILDING B. WING		03/16/2012
	ROVIDER OR SUPPLIER		8201 W	ADDRESS, CITY, STATE, ZIP CODE V WASHINGTON ST JAPOLIS, IN 46231	
	GTON HEALTH CA SUMMARY S' (EACH DEFICIEN		8201 W	WASHINGTON ST	DATE DATE
				Assurance Committee will me monthly to identify issues and implement appropriate plans correct deficiencies including	d to

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IKCV11

Facility ID: 000393

If continuation sheet

Page 24 of 26

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING 00		(X3) DATE SURVEY COMPLETED			
		155383	A. BUILDING B. WING		03/16/2012			
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	•			
WASHIN	GTON HEALTH CA	RE CENTER	8201 W WASHINGTON ST INDIANAPOLIS, IN 46231					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE			
				not limited to, infection control resident liability and providing of items/services not covered Medicare/Medicaid, informing Residents of their rights, inclusive availability of state survey results utilizing audit tools. Ite in grievance logs utlized by Residents, families, visitors, a staff will be reviewed by Quali Assurance Committee. State survey results audit tool will butilized for availability and post of survey results weekly x 4 weeks, monthly x 6, then quarterly thereafter to ensure physical posting and availability survey results. Residents Rigaudit tool will be utilized for Residents Rights, Ombudsmand services not covered by Medicare and Medicaid week 4 weeks, monthly x 6, then quarterly thereafter to ensure admissions are provided with Residents Rights, Ombudsmand information, and services not covered by Medicare and Medicaid. In addition Resident Council members, we remain familiar with the availability. Infection Control audit tool will be utilized for Infection Control 5 x weekly for weeks, then monthly thereafted ensure staff utilize appropriated infection control practices, including but not limited to, preventing the spread of infection control practices, including but not limited to, preventing the spread of infection control practices, including but not limited to, preventing the spread of infection control practices, including but not limited to, preventing the spread of infection control practices, including but not limited to, preventing the spread of infection control practices, including but not limited to, preventing the spread of infection control practices, including but not limited to, preventing the spread of infection control actions on isolation for the spread of infection control actions on isolation for the spread of infection control actions on isolation for the spread of infection control actions on isolation for the spread of infection control actions on isolation for the spread of infection control actions on isolation for the spread of infection control actions of the	I, list by ding ms and ity esting lity of ghts an, ly x new an an ats, will br 4 er to e e e e e e e e e e e e e e e e e e			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IKCV11

Facility ID: 000393

If continuation sheet

Page 25 of 26

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2012 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER WASHINGTON HEALTH CARE CENTER INDIANAPOLIS, IN 46231 INDIANAPOLIS, IN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155383		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMP	(X3) DATE SURVEY COMPLETED 03/16/2012			
WASHINGTON HEALTH CARE CENTER INDIANAPOLIS, IN 46231 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX (EACH CORRECTION GEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) an action plan will be developed, one-on-one re-education and/or disciplinary action may occur for	NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) An action plan will be developed, one-on-one re-education and/or disciplinary action may occur for	WASHINGTON HEALTH CARE CENTER								
one-on-one re-education and/or disciplinary action may occur for	PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION HOULD BE APPROPRIATE	COMPLETION		
	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	an action plan will be d one-on-one re-education disciplinary action may	leveloped, on and/or	DATE		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IKCV11

Facility ID: 000393

If continuation sheet

Page 26 of 26